DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 1 — 0 2 3
2. STATE: Minnesota
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 8, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 440.10 & 42 CFR 440.110

7. FEDERAL BUDGET IMPACT:
a. FFY '02 $ 0
b. FFY '03 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Att. 3.1-A, pp. 11-11a, 42-42d, 43-43d, 44-44f
Att. 3.1-A, pp. 10-10a, 41-41d, 42-42d, 43-43f

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Att. 3.1-A, pp. 11-11a, 42-42b, 43-43c, 44-44e
Att. 3.1-B, pp. 10-10a, 41-41b, 42-42c, 43-43e

10. SUBJECT OF AMENDMENT:
Inpatient Hospital Services, Physical Therapy, Occupational Therapy, and Speech, Language and Hearing Therapy

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Mary B Kennedy

13. TYPED NAME:
Mary B. Kennedy

14. TITLE:
Medicaid Director

15. DATE SUBMITTED:
December 14, 2001

16. RETURN TO:
Stephanie Schwartz
Federal Relations
Minnesota Department of Human Services
444 Lafayette Road North
St. Paul, Minnesota 55155-3853

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
12/20/01

18. DATE APPROVED:
6/21/02

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
October 8, 2001

20. SIGNATURE OF REGIONAL OFFICIAL:
Cheryl A Harris

21. TYPED NAME:
Cheryl A. Harris

22. TITLE: Associate Regional Administrator
Division of Medicaid and Children's Health

23. REMARKS:

RECEIVED
DEC 20 2001
DMCH - MI/MN/WI

FORM HCFA-179 (07-92)

Instructions on Back

LIMITATIONS TO THE AMOUNT, DURATION, AND SCOPE OF COVERED SERVICES (Referenced by the number of the service described in preceding pages)

1. Inpatient hospital services:

- Certification of admission is a condition of ~~reimbursement~~ payment. Inpatient stays not deemed medically necessary by the state agency or the designated medical review agent are not covered.

- Inpatient chemical dependency treatment will require at least 30 hours per week of therapy/counseling including group, collateral, and individual therapy/counseling.

- Hospitals must comply with federal regulations concerning informed consent and statements of acknowledgment for voluntary sterilization procedures, ~~and~~ hysterectomies, and therapeutic abortions.

- Detoxification is covered only when inpatient hospitalization is medically necessary because of conditions resulting from withdrawal or conditions occurring in addition to withdrawal ~~or resulting from withdrawal~~, e.g., conditions resulting from injury or accident or medical complications during detoxification such as delirium ~~which~~ that necessitate the constant availability of physicians and registered nurses and/or complex medical equipment found only in ~~a hospital~~ an inpatient setting.

- Leave days, leaves of absence, and reserve beds are not covered.

- A private room must be certified by a licensed physician to be medically necessary, unless the hospitals private room rate does not exceed its semi-private room rate.

1. Inpatient hospital services. (continued)

- Abortion related services are covered when the abortion is medically necessary to prevent the death of a pregnant woman, and in cases where the pregnancy is the result of rape and incest. Cases of rape and incest must be reported to legal authorities unless the treating physician documents that the woman was physically or psychologically unable to report.

- Laboratory, ~~and~~ x-ray, and any additional services provided as a result of a recipient's scheduled visit that immediately precedes hospital admission as an inpatient are not covered as separate services.

- Providers who administer pediatric vaccines as noted in item 5.a., Physicians' services within the scope of their licensure must enroll in the Minnesota Vaccines for Children Program.

11.a. Physical therapy services.

Coverage is limited to:

(1) Services prescribed by a physician~~, physician assistant~~ or ~~nurse~~ other licensed practitioner of the healing arts within the scope of the practitioner's practice under state law.

(2) Services provided by a physical therapist or a physical therapist assistant who is under the direction of a physical therapist.

(3) Services specified in a plan of care that is reviewed and revised as medically necessary by the recipient's attending physician~~, physician assistant~~ or ~~nurse~~ other licensed practitioner of the healing arts at least once every 60 days. If the service is a Medicare covered service and the recipient is eligible for Medicare, the plan of care must be reviewed at the intervals required by Medicare and the recipient must be visited by the physician or the physician's delegate as required by Medicare.

(4) ~~(A)~~ Services that are: ~~rehabilitative and therapeutic~~

(A) Restorative therapy and are provided to a recipient whose functional status is expected by the physician or ~~nurse~~ other licensed practitioner of the healing arts to progress toward or achieve the objectives in the recipient's plan of care within a 60-day period; or

(B) ~~Services that are specialized~~ Specialized maintenance therapy provided to a recipient ~~who~~ whose condition cannot be maintained or treated only through rehabilitative nursing services or services of other care providers, or by the recipient because ~~they have one of the following conditions~~ the recipient's medical condition(s) result in:

(i) Spasticity or severe contracture that interferes with the recipient's activities of daily living or the completion of routine nursing care, or decreased functional ability compared to the recipient's previous level of function;

11.a. Physical therapy services. (continued)

(ii) A chronic condition that results in physiological deterioration and that requires specialized maintenance therapy services or equipment to maintain strength, range of motion, endurance, movement patterns, activities of daily living, cardiovascular function, integumentary status, ~~or~~ positioning necessary for completion of the recipient's activities of daily living, or decreased abilities relevant to the recipient's current environmental demands, or;

(iii) ~~An orthopedic condition that may lead to physiological deterioration~~ health and ~~require therapy intervention by a physical therapist to maintain strength, joint mobility and cardiovascular function,~~ safety risks for the recipient

~~(iv) Chronic pain that interferes with functional status and is expected by the physician to respond to therapy;~~

~~(v) Skin breakdown that requires a therapy procedure other than a rehabilitative nursing service~~.

Specialized maintenance therapy must meet at least one of the following:

(i) prevents deterioration and sustains function;

(ii) for a chronic or progressive medical condition, provides interventions that enable a recipient to live at his or her highest level of independence; or

(iii) provides treatment interventions for a recipient who is progressing but not at a rate comparable to the expectations of rehabilitative and therapeutic care.

11.a. Physical therapy services. (continued)

Physical therapist is defined as a graduate of a program of physical therapy approved by both the ~~Council~~ Committee on ~~Medical~~ Allied Health Education and Accreditation of the American Medical Association and the American Physical Therapy Association or its equivalent. Physical therapists must meet state licensure requirements when they are developed.

Physical therapist assistant is defined as one qualified under the rules of the Board of Medical Examiners. These rules define a physical therapist assistant as a skilled technical worker who is a graduate of a physical therapy assistant educational program accredited by the American Physical Therapy Association or a comparable accrediting agency. A physical therapist assistant performs selected physical therapy treatments and related duties as delegated by the physical therapist to assist the physical therapist in patient, client or resident related activities.

Direction is defined as the actions of a physical therapist who instructs the physical therapist assistant in specific duties to be performed, monitors the provision of services on-site ~~as the therapy assistant provides the services, is on premises~~ and documents the appropriateness of the services not less than every sixth treatment session, ~~of each recipient when treatment is provided by a physical therapist assistant~~ and meets the other supervisory requirements specified in the rules of the Board of Medical Examiners.

Coverage does *not* include:

(1) Services provided in a nursing facility, ICF/MR, or day training and habilitation services center, if the cost of physical therapy has been included in the facility's per diem, such as:

(A) Services for contracture that are not severe and do not interfere with the recipient's functional status or the completion of nursing care as required for licensure of the long-term care facility;

~~(2)~~ (B) Ambulation of a recipient who has an established gait pattern~~.~~ ;

~~(3)~~ (C) Services for conditions of chronic pain that does not interfere with the recipient's functional status and that can be maintained by routine nursing measures~~.~~ ;

11.a. Physical therapy services. (continued)

~~(4)~~ (D) Services for activities of daily living when performed by the therapist, therapy assistant or therapy aide~~.~~ ; and

~~(5)~~ (E) Bowel and bladder retraining programs.

~~(6)~~ (2) Arts and crafts activities for the purposes of recreation.

~~(7)~~ (3) Services that are not documented in the recipient's health care record.

~~(8)~~ (4) Services that are not designed to improve, ~~or~~ maintain, or prevent deterioration of the functional status of a recipient with a ~~physical impairment~~ medical condition.

~~(9)~~ (5) Services by more than one provider of the same type for the same diagnosis unless the service is provided by the school district as specified in the recipient's individualized education plan.

~~(10)~~ (6) A rehabilitative and therapeutic service that is ~~denied Medicare payment because of the provider's failure to comply~~ furnished by a provider not enrolled with Medicare ~~requirements~~ , or, in the case of dual eligibles, furnished by a provider who does not first bill Medicare.

~~(11)~~ (7) Evaluations or reevaluations performed by a physical therapist assistant.

~~(12)~~ (8) ~~Services provided in a nursing facility, ICF/MR or day training and habilitation services centers, if the cost of physical therapy has been included in the facility's per diem.~~

~~(13)~~ Services provided by a physical therapist other than the therapist billing for the services, unless the physical therapist provided the service as an employee of a rehabilitation agency, long-term care facility, outpatient hospital, clinic, or physician; in which case the agency, facility or physician must bill for the service.

~~(14)~~ (9) Services provided by an independently enrolled physical therapist ~~who is not Medicare certified~~.

11.a. Physical therapy services. (continued)

~~(15)~~ ~~Services provided by an independently enrolled physical therapist who does not maintain an office at his or her expense.~~

~~(16)~~(10) For long-term care recipients, services for which there is not a statement every 30 days in the clinical record by the therapist providing or supervising the services that the nature, scope, duration, and intensity of the services provided are appropriate to the medical condition of the recipient. This statement is not required for an initial evaluation.

11.b. Occupational therapy services.

Coverage is limited to:

(1) Services prescribed by a physician~~, physician assistant~~ or ~~nurse~~ other licensed practitioner of the healing arts within the scope of the practitioner's practice under state law.

(2) Services provided by an occupational therapist or an occupational therapy assistant who is under the direction of an occupational therapist.

(3) Services specified in a plan of care that is reviewed and revised as medically necessary by the recipient's attending physician~~, physician assistant~~ or ~~nurse~~ other licensed practitioner of the healing arts at least once every 60 days. If the service is a Medicare covered service and the recipient is eligible for Medicare, the plan of care must be reviewed at the intervals required by Medicare and the recipient must be visited by the physician or the physician's delegate as required by Medicare.

(4) ~~(A)~~ Services that are: ~~rehabilitative and therapeutic~~

(A) Restorative therapy and are provided to a recipient whose functional status is expected by the physician or ~~nurse~~ other licensed practitioner of the healing arts to progress toward or achieve the objectives in the recipient's plan of care within a 60-day period; or

(B) ~~Services that are specialized~~ Specialized maintenance therapy provided to a recipient ~~who~~ whose condition cannot be maintained or treated only through rehabilitative nursing services or services of other care providers, or by the recipient because ~~they have one of the following conditions~~ the recipient's medical conditions(s) result in:

(i) Spasticity or severe contracture that interferes with the recipient's activities of daily living or the completion of routine nursing care, or decreased functional ability compared to the recipient's previous

11.b. Occupational therapy services. (continued)

level of function;

(ii) A chronic condition that results in physiological deterioration and that requires specialized maintenance therapy services or equipment to maintain strength, range of motion, endurance, movement patterns, activities of daily living, cardiovascular function, integumentary status, ~~or~~ positioning necessary for completion of the recipient's activities of daily living, or decreased abilities relevant to the recipient's current environmental demands, or;

(iii) ~~An orthopedic condition that may lead to physiological deterioration~~ health and ~~require therapy intervention by an occupational therapist to maintain strength, joint mobility and cardiovascular function~~ safety risks for the recipient;

~~(iv) Chronic pain that interferes with functional status and is expected by the physician to respond to therapy;~~

~~(v) Skin breakdown that requires a therapy procedure other than a rehabilitative nursing service~~.

Specialized maintenance therapy must meet at least one of the following:

(i) prevents deterioration and sustains function;

(ii) for a chronic or progressive medical condition, provides interventions that enable a recipient to live at his or her highest level of independence; or

(iii) provides treatment interventions for a recipient who is progressing but not at a rate comparable to the expectations of rehabilitative and therapeutic care.

11.b. Occupational therapy services. (continued)

Occupational therapist is defined as an individual currently registered by the American Occupational Therapy Association as an occupational therapist.

Occupational therapy assistant is defined as an individual who has successfully completed all academic and field work requirements of an ~~associate degree in~~ occupational therapy ~~and who is currently certified~~ assistant program approved or accredited by the Accreditation Council for Occupational Therapy Education and who is currently certified by the American Occupational Therapy Certification Board as an occupational therapy assistant.

Direction is defined as the actions of an occupational therapist who instructs the occupational therapy assistant in specific duties to be performed, and monitors the provision of services on-site ~~as the therapy assistant provides the service, and is on premises~~ and documents the appropriateness of the services not less than every sixth treatment session of each recipient when ~~treatment is provided by an occupational therapy assistant~~.

Coverage does *not* include:

(1) Services provided in a nursing facility, ICF/MR, or day training and habilitation service center, if the cost of occupational therapy has been included in the facility's per diem, such as:

(A) Services for contracture that are not severe and do not interfere with the recipient's functional status or the completion of nursing care as required for licensure of the long-term care facility~~.~~;

~~(2)~~ (B) Ambulation of a recipient who has an established gait pattern~~.~~;

~~(3)~~ (C) Services for conditions of chronic pain that does not interfere with the recipient's functional status and that can be maintained by routine nursing measures~~.~~;

~~(4)~~ (D) Services for activities of daily living when performed by the therapist, therapy assistant or therapy aide~~.~~; and

~~(5)~~ (E) Bowel and bladder retraining programs.

11.b. Occupational therapy services. (continued)

~~(6)~~(2) Arts and crafts activities for the purpose of recreation.

~~(7)~~(3) Services that are not documented in the recipient's health care record.

~~(8)~~(4) Services that are not designed to improve, ~~or~~ maintain, or prevent deterioration of the functional status of a recipient with a ~~physical impairment~~ medical condition.

~~(9)~~(5) Services by more than one provider of the same type for the same diagnosis unless the service is provided by the school district as specified in the recipient's individualized education plan.

~~(10)~~(6) A rehabilitative and therapeutic service that is ~~denied Medicare payment because of the provider's failure to comply~~ furnished by a provider not enrolled with Medicare ~~requirements~~ , or, in the case of dual eligibles, furnished by a provider who does not first bill Medicare.

~~(11)~~(7) Evaluations or reevaluations performed by an occupational therapy assistant.

~~(12)~~(8) ~~Services provided in a nursing facility, ICF/MR or day training and habilitation services center, if the cost of occupational therapy has been included in the facility's per diem.~~

~~(13)~~ Services provided by an occupational therapist other than the therapist billing for the service, unless the occupational therapist provided the service as an employee of a rehabilitation agency, long-term care facility, outpatient hospital, clinic, or physician; in which case, the agency, facility or physician must bill for the

11.b. Occupational therapy services. (continued)

~~(14)~~ (9) Services provided by an independently enrolled occupational therapist ~~who is not Medicare certified~~.

~~(15) Services provided by an independently enrolled occupational therapist who does not maintain an office at his or her own expense.~~

~~(16)~~ (10) For long-term care recipients, services for which there is not a statement every 30 days in the clinical record by the therapist providing or supervising the services that the nature, scope, duration, and intensity of the services provided are appropriate to the medical condition of the recipient. This statement is not required for an initial evaluation.

11.c. Speech, language, and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist).

Coverage of **speech and language therapy services** is limited to:

(1) Services provided upon written referral by a physician~~, physician assistant~~ or ~~nurse~~ licensed practitioner of the healing arts within the scope of the practitioner's practice under state law, or, in the case of a resident of a long-term care facility, on the written order of a physician as required by 42 CFR §483.45.

(2) Services provided by a speech language pathologist or a person completing the clinical fellowship year required for certification as a speech-language pathologist under the supervision of a speech-language pathologist.

(3) Services specified in a plan of care that is reviewed and revised as medically necessary by the recipient's attending physician or other licensed practitioner of the healing arts at least once every 60 days. If the service is a Medicare covered service and the recipient is eligible for Medicare, the plan of care must be reviewed at the intervals required by Medicare and the recipient must be visited by the physician or the physician's delegate as required by Medicare.

(4) ~~(A)~~ Services that are:

(A) Restorative therapy and are provided to a recipient whose functional status is expected by the physician~~, physician assistant~~ or ~~nurse~~ licensed practitioner of the healing arts to progress toward or achieve the objectives in the recipient's plan of care within a 60-day period; or

(B) Specialized maintenance therapy ~~services necessary for maintaining the patient's current level~~ provided to a recipient whose condition cannot be maintained or treated only through rehabilitative nursing services or services of ~~functioning~~ other care

11.c. Speech, language, and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist). (continued)

providers, or ~~for preventing deterioration of~~ by the ~~patient's~~ recipient because the recipient's medical condition(s) ~~.~~ result in:

(i) Decreased functional ability compared to the recipient's previous level of function;

(ii) Decreased abilities relevant to the recipient's current environmental demands; or

(iii) Health and safety risks for the recipient.

Specialized maintenance therapy must meet at least one of the following:

(i) prevents deterioration and sustains function;

(ii) for a chronic or progressive medical condition, provides interventions that enable a recipient to live at his or her highest level of independence; or

(iii) provides treatment interventions for a recipient who is progressing but not at a rate comparable to the expectations of rehabilitative and therapeutic care.

~~(4)~~ (5) For long term care recipients, services for which there is a statement in the clinical record every 30 days that the nature, scope, duration, and intensity of the services provided are appropriate to the medical condition of the recipient. This statement is not required for an initial evaluation.

11.c. Speech, language, and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist). (continued)

~~(5) Services specified in a plan of care that is reviewed and revised as medically necessary by the recipient's attending physician, physician assistant or nurse practitioner at least once every 60 days. If the service is a Medicare covered service and the recipient is eligible for Medicare, the plan of care must be reviewed at the intervals required by Medicare and the recipient must be visited by the physician or the physician's delegate as required by Medicare.~~

Speech-language pathologist is defined as a person who has a certificate of clinical competence in speech-language pathologies from the American Speech-Language-Hearing Association and meets the state licensure and registration requirements for the services the person provides.

Coverage of **speech-language therapy services** does *not* include:

(1) Services that are not documented in the recipient's health care record.
(2) Services by more than one provider of the same type for the same diagnosis unless the service is provided by a school district as specified in the recipient's individualized education plan.
(3) Except in the case of independently enrolled providers, services that are ~~denied~~ furnished by a provider not enrolled with Medicare ~~payment because of the provider's failure to comply with~~ , or, in the case of dual eligibles, furnished by a provider who does not first bill Medicare ~~requirements~~.
(4) Services that are provided without written referral.
(5) Services not medically necessary.
(6) Services that are not part of the recipient's plan of care.
(7) Services provided in a nursing facility, ICF/MR or day training and habilitation services center if the cost of speech-language pathology has been included in the facility's per diem.

11.c. Speech, language, and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist). (continued)

(8) Services provided by a speech-language pathologist other than the pathologist billing for the service, or a person completing the clinical fellowship year under the supervision of the pathologist, unless the pathologist provided the service as an employee of a rehabilitation agency, long-term care facility, outpatient hospital, clinic, or physician; in which case, the agency, facility or physician must bill for the service.

(9) Services provided by an independently enrolled speech language pathologist who does not maintain an office at his or her own expense.

Coverage of **hearing (audiology) therapy services** is limited to:

(1) Services provided upon written referral by a physician~~, physician assistant~~ or ~~nurse~~ other licensed practitioner of the healing arts within the scope of the practitioner's practice under state law.

(2) Services provided by an independently enrolled audiologist who maintains an office at their own expense or an audiologist who is employed by and providing audiology services in a hospital, rehabilitation agency, home health agency, or clinic.

(3) ~~Services provided to a recipient who is expected to progress toward or achieve the objective specified in their plan of care within a 60-day period.~~

~~(4)~~ Services ~~provided under~~ specified in a ~~written treatment~~ plan ~~which~~ of care that is reviewed and revised as medically necessary at least once every 60 days~~, with certification and recertification~~ by the ~~ordering~~ attending physician or ~~physician assistant~~ other licensed practitioner of the healing arts. If the service is ~~provided to~~ a Medicare covered service and the recipient is eligible for Medicare ~~beneficiary and covered by Medicare~~, the ~~physician or physician delegate must review the~~ plan of care must be reviewed at the intervals required

11.c. Speech, language, and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist). (continued)

(3) Services provided by an audiologist other than the audiologist billing for the services, or a person completing the clinical fellowship year under the supervision of the audiologist, unless the audiologist provided the services in a hospital, rehabilitation agency, home health agency, or clinic, or as an employee of a physician or long-term care facility; in which case the contracting or employing facility, agency, or person must bill for the services.

Hearing aid services: After a physician rules out medical and surgical contraindications, the physician refers the recipient for an audiologic evaluation. An audiologist or otolaryngologist provides audiologic testing, and if a hearing aid is indicated, prescribes a specific hearing aid offered under the hearing aid volume purchase contract or refers the recipient to a hearing aid services provider.

Payment is made to hearing aid services providers for hearing aids, dispensing fees, hearing aid repairs, accessories, ear molds when not provided with the hearing aid and batteries.

Coverage of **hearing aids** is limited to:

(1) One monaural or one set of binaural hearing aids within a period of five years unless prior authorized. A hearing aid will not be replaced when the recipient has received a replacement hearing aid twice within the five year period previous to the date of the request.
(2) Non-contract hearing aids require prior authorization.

Coverage of **hearing aids** does *not* include:

(1) Replacement batteries provided on a scheduled basis regardless of their actual need.
(2) Services specified as part of the contract price when billed on a separate claim for payment. This includes any charges for repair of hearing aids under warranty.
(3) Routine screening of individuals or groups for identification of hearing problems.
(4) Separate reimbursement for postage, handling, taxes, mileage, or pick-up and delivery.

11.c. Speech, language, and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist). (continued)

(5) Nonelectronic hearing aids, telephone amplifiers, vibrating bed alarms, phone handsets, visual telephone ringers, swim molds, ear plugs, dry aid kits, and battery chargers.
(6) Maintenance, cleaning, and checking of hearing aids, unless there has been a request or referral for the service by the person who owns the hearing aid, the person's family, guardian or attending physician.
(7) Loaner hearing aid charges.
(8) Canal type hearing aids.
(9) A noncontract hearing aid that is obtained without prior authorization.
(10) Services included in the dispensing fee when billed on a separate claim for payment.
(11) Hearing aid services to a resident of a long-term care facility if the services did not result from a request by the resident, a referral by a registered nurse or licensed practical nurse who is employed by the long-term care facility, or a referral by the resident's family, guardian or attending physician.
(12) Hearing aid services prescribed or ordered by a physician if the physician or entity commits a felony listed in United States Code, title 42, section 1320a-7b, subject to the "safe harbor" exceptions listed in 42 CFR 1001.952.
(13) Replacement of a lost, stolen or damaged hearing aid if MA has provided three hearing aids in the five years prior to the date of the request for a replacement.

LIMITATIONS TO THE AMOUNT, DURATION, AND SCOPE OF COVERED SERVICES (Referenced by the number of the service described in preceding pages)

1. Inpatient hospital services:

- Certification of admission is a condition of ~~reimbursement~~ payment. Inpatient stays not deemed medically necessary by the state agency or the designated medical review agent are not covered.

- Inpatient chemical dependency treatment will require at least 30 hours per week of therapy/counseling including group, collateral, and individual therapy/counseling.

- Hospitals must comply with federal regulations concerning informed consent and statements of acknowledgment for voluntary sterilization procedures, ~~and~~ hysterectomies, and therapeutic abortions.

- Detoxification is covered only when inpatient hospitalization is medically necessary because of conditions resulting from withdrawal or conditions occurring in addition to withdrawal ~~or resulting from withdrawal~~, e.g., conditions resulting from injury or accident or medical complications during detoxification such as delirium ~~which~~ that necessitate the constant availability of physicians and registered nurses and/or complex medical equipment found only in ~~a hospital~~ an inpatient setting.

- Leave days, leaves of absence, and reserve beds are not covered.

- A private room must be certified by a licensed physician to be medically necessary, unless the hospitals private room rate does not exceed its semi-private room rate.